STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 01 B. WING	08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/09/12 Facility Number: 012534 Provider Number: 155792 AIM Number: 201028420 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Countryside Meadows LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	resident sleeping rooms. The facility has a capacity of 171 and had a census of 135 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 12 doors serving hazardous areas such as the kitchen are provided with a positive latching device to latch each door into the door frame. This deficient practice could affect 58 residents and any staff or visitors in the vicinity of the kitchen entry door from the Dining Room and the kitchen entry door from the service corridor. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:20 p.m. on 08/09/12, a positive latching device was not provided for the kitchen entry door from the Dining Room and the kitchen entry door from the service corridor. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the kitchen entry door from the Dining Room and the kitchen entry door from the service corridor are each not equipped with a	K0029	Corrective action: a positive latching device was added to the kitchen doors.Other residents having the potential to be affected: This had the potential to affect all residents, however, no additional doors needed a positive latching device added. In the event a latching device is needed, one will be added in accordance to 7.2.1.8 18.3.2.1Systematic changes: Monthly checks will be completed as part of the preventative maintenance program. In the event that a latching device is added, it will be included with the monthly egress door checks and installed in accordance to 7.2.1.8 18.3.2.1Monitoring: Monthly checks will be completed as part of the preventative maintenance program. In the event that a latching device is added, it will be included with the monthly egress door checks. Changes to a door or door frame will be brought to monthly Safety Meeting for review upon each occurrence. Monthly egress door checks will be brought to Safety meeting x 3 months to ensure compliance.Date of completion:	08/24/2012

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	positive latching device to latch each door into the door frame. 3.1-19(b)		8-24-12	

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K0039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4 Based on observation and interview, the facility failed to ensure 1 of 6 exit access corridors had a clear and unobstructed exit width of at least 8 feet (96 inches). This deficient practice could affect 26 residents and any staff and visitors if needing to exit the facility from the service corridor in the event of an emergency. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 1:20 p.m. on 08/09/12, two vending machines and a four shelf "No Name" laundry rack were being stored in the service corridor. The service corridor is marked as an exit and the unobstructed width of the service corridor measured eight feet wide. The two vending machines and the laundry rack each protruded three feet into the service corridor which served to decrease the exit corridor width from eight feet to five feet. Based on interview at the time of observation, the Maintenance	K0039	Corrective action: vending machines and laundry rack were removed.Other residents having the potential to be affected. Even though the service hallway is not a resident access area, all residents could have the potential to be affected in the event of an emergency. The vending machines and laundry rack were removed to ensure 8'clearance along the emergency exit hallway.Systematic changes: The laundry rack was removed and the vending machines placed in another area of the facility. The access corridor will be monitored daily by the Mainteance Director/Housekeeping-Laundry Spvsr/or designee for stored items to ensure 8' clearance in the hallway remains. Weekly monitoring of the access corrider will be brought to monthly Safety committee monthly, ongoing, to evaluate compliance. ED to educate IDT on 8-31-12 in regard to life safety code standard 18.2.3.3, 18.2.3.4.Monitoring: Maintenance Director/Housekeeping-Laundry Spvsr/ED (executive Director) will monitor access corridor mentioned weekly to ensure	09/08/2012

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	Supervisor stated the service corridor is marked as an emergency exit and acknowledged the vending machines and the No Name laundry rack decreased the unobstructed width of the service corridor to less than eight feet. 3.1-19(b)		compliance. If non-compliance is <95%, an action plan will be developed.Date of compliance 9-8-12	